Washington State Health Care Authority
Public Employees Benefits Board

Student Certification/Change

(complete form on back)

To qualify for PEBB coverage, your student dependent must be:

- Age 20 through 23.
- Attending high school or a registered student at an accredited secondary school, college, university, vocational school, or school of nursing.

Dependent student eligibility:

- Begins the first day of the month of the quarter or semester the student is registered.
- Ends the last day of the month the student stops attending school or the quarter or semester ends, whichever comes first.
- Continues year-round for students who attend three of the four school quarters or two of three school semesters.
- Continues for up to three months after graduation if (1) you are covered at the same time; (2) the dependent has not reached age 24; and (3) the dependent meets all other eligibility requirements under WAC 182-12-260[4].
- Includes married children who qualify as your dependent under Internal Revenue Code (see WAC 182-12-260[4]).

Instructions (Please complete the form on the back.)

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- If you are enrolling your dependent as a student for the first time, or re-enrolling a student dependent, please submit this form **30 days before** your dependent returns to school.
- You must mail or hand-deliver this form if you want to terminate coverage for your dependent. This change cannot be made by telephone, fax, or e-mail.
- If you terminate your dependent's coverage due to a qualifying event (for example, he or she loses dependent status), you must notify PEBB Benefits Services in writing within **60 days** of the event. If you don't, your dependent will lose his or her right to extend PEBB coverage.
- Notify PEBB Benefits Services if your student's status changes. If you have questions, call us at 1-800-200-1004.
- Report address corrections to your personnel, payroll, or benefits office (if you are an employee) or to PEBB Benefits Services (all other members).
- **You must sign and date this form.**

Mail completed form to:
Washington State Health Care Authority
PEBB Benefits Services
P.O. Box 42684
Olympia, WA 98504-2684

Or fax to: 360-923-2608

You must mail or hand-deliver this form if you want to terminate coverage for your dependent.

Student Certification/Change

SECTION 1: Subscriber Information

Name	Social security number
Address	Phone Work ( ) Home ( )

SECTION 2: Dependent Information *List only one dependent per form.*

Dependent name	Social security number
Address (if different from subscriber, please notify your personnel or payroll office)	Date of birth

Is this dependent married? ❑ Yes ❑ No If yes, date of marriage _____

If yes, does this dependent qualify as your dependent under the Internal Revenue Code? ❑ Yes ❑ No

SECTION 3: Enrollment Information

Full school name	City, State	Registrar's phone ( )

Is your student dependent currently attending school? ❑ Yes ❑ No Last quarter/semester attended (month/year) _____

Expected school attendance for the 12 months following current enrollment

QUARTER

❑ Fall Month/Year _____ ❑ Winter Month/Year _____ ❑ Spring Month/Year _____ ❑ Summer Month/Year _____

SEMESTER

❑ Fall Month/Year _____ ❑ Spring Month/Year _____ ❑ Summer Month/Year _____ ❑ Other _____

Expected graduation date (Month/Year) _____

Note: Your dependent will be certified only for the attendance checked above. See eligibility requirements on the front of this form for details.

SECTION 4: Notice of Qualifying Event/Request to Terminate Dependent's Coverage

Complete only if your dependent is no longer eligible for PEBB coverage, based on eligibility rules on the front of this form. You must notify us in writing within **60 days** after a qualifying event (such as a dependent's loss of dependent status). If you don't, your dependent will lose the right to choose COBRA or other continuation coverage.

When you notify us about your dependent's loss of dependent status (and when we request it), you must provide satisfactory documentation of the qualifying event (for example, a marriage certificate showing the date the dependent married or a transcript or other satisfactory evidence showing the last date of student enrollment).

If the student has graduated, he or she may be eligible for coverage for three months after graduation. Graduation is defined as the successful completion of studies to earn a degree/certificate, not the date of the graduation ceremony. If you do not want your dependent to be covered for the three-month period after graduation, please notify us in writing.

❑ My dependent is no longer eligible for PEBB coverage, effective _____ (month/day/year).

Last date of school enrollment _____ (month/day/year).

❑ My dependent has graduated; his or her graduation date was _____ (month/day/year).

SECTION 5: Subscriber Certification and Signature *(Required)*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, I must repay any claims paid by my health plan or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we qualified. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

The PEBB Benefits Services Program will verify eligibility for me and my family members. The PEBB Benefits Services Program has the right to request completion of this form or copies of my student's transcripts at any time.

This form replaces all previous forms and submissions I have made for PEBB benefits.

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov**.

Print name _____

Signature (required) _____ Date _____